82 - 1969

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No.

In the Supreme Court

of the United States

OCTOBER TERM, 1982

KLAMATH-LAKE PHARMACEUTICAL ASSOCIATION, an Oregon non-profit corporation, on behalf of its assignors,

Petitioner,

v.

KLAMATH MEDICAL SERVICE BUREAU, an Oregon non-profit corporation, and KLAMATH BUREAU PHARMACY, INC. a now dissolved Oregon profit corporation,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JURISDICTIONAL STATEMENT

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QUESTIONS PRESENTED

1. Is provision of an insurance benefit "in kind" rather than in cash the "business of insurance" under the McCarran-Ferguson Act exemption to the antitrust laws?

2. Is there an unlawful "tying" agreement when the insured is given the choice to select different types of benefit coverages?

3. Is there "coercion", "intimidation", or "boycott" within the meaning of the McCarran-Ferguson Act when an insured is free to purchase different forms of drug benefit, each of which provide for payment in cash or in kind?

4. Whether the *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) decision of this Court holds that agreements between health care providers and insurance companies precludes

an insurer from claiming the exemption shelter of the McCarran-Ferguson Act with respect to the terms of insurance with its insured.

5. Whether the Courts below correctly concluded that there was no genuine issue of material fact which would foreclose entry of summary judgment.*

* Neither KMSB nor KBPI have a parent, subsidiary or affiliate company.

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KLAMATH-LAKE PHARMACEUTICAL ASSOCIATION, an Oregon non-profit corporation, on behalf of its assignors,

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KLAMATH MEDICAL SERVICE BUREAU, an Oregon non-profit corporation, and KLAMATH BUREAU PHARMACY, INC., a now-dissolved Oregon profit corporation,

Respondents.

RESPONDENTS' BRIEF IN OPPOSITION

STATEMENT OF THE CASE

Plaintiff-Appellant ("Association") filed suit for damages and injunctive relief, on behalf of certain assignors, claiming violation of Sections 1 and 2 of the Sherman Act; of Section 2 of the

Robinson-Patman Act (15 U.S.C. § 13); and of Section 3 of the Clayton Act (15 U.S.C. § 14); and sought damages proximately relating to these claims (CR 1, pp. 1-20).

There are two defendants in the case. The first, Klamath Medical Service Bureau ("KMSB"), is a health care contractor governed under the Insurance Code of the State of Oregon. The second defendant was Klamath Bureau Pharmacy, Inc. ("KBPI"). It was a for-profit corporation which provided prescription drugs to KMSB subscribers and to others. In addition to generally denying Association's complaint, defendants alleged a variety of affirmative defenses, including whether the claims of the Association were barred, in whole or in part, by the applicable provisions of the McCarran-Ferguson Act, 15 U.S.C. §§ 1012, 1013 (CR 7, pp. 7-8).

On March 20, 1979, Association moved for partial summary judgment with respect

to the McCarran-Ferguson defense (CR 10). On April 25, 1979, the trial court held, based upon the concession of the defendants, that KBPI was not exempt (CR 18).

On October 30, 1979, KMSB moved for partial summary judgment, based upon the McCarran-Ferguson Act, with respect to:

1. All alleged conduct undertaken by KMSB from July 1, 1976, to and including the date the complaint was filed; and

2. All alleged violations of the Sherman Act prior to July 1, 1976 which were predicated solely upon the contract of insurance between KMSB and its insureds (CR 51, 53).

The trial court, on the 27th day of February, 1981, entered partial summary judgment in favor of KMSB on its motion (CR 71).

Thereafter, on August 10, 1981 defendants filed their motion for summary

judgment on the remaining issues in the case, to-wit:

1. Whether the assignments were enforceable;

2. Whether the defendants had violated the Robinson-Patman Act; and

3. Whether there was some unlawful agreement between KMSB and KBPI (CR 88-90).

On October 7, 1971 Judge Solomon held that defendants were entitled to summary judgment (CR 112) and entered judgment on October 8, 1981 (CR 115).

Association filed a timely notice of appeal with the Ninth Circuit Court of Appeals. On March 4, 1983, it affirmed the trial court's decision (App. A, pp. 1A-27A).

On June 2, 1983, Association filed its petition for writ of certiorari. It has confined its petition to matters arising under Sections 1 and 2 of the Sherman Act. In consequence, review has not been sought

of the Ninth Circuit's decision upon the Clayton and Robinson-Patman Act issues.

FACTUAL BACKGROUND

KMSB is a health care insurer authorized to engage in the provision of health coverage. It issues four basic forms of health insurance policy. Only one of these forms of policy is in question here.

The first type provided both major medical and basic benefit coverage for pharmaceutical risks. The basic benefits provision included a pharmacy benefit. This basic benefit permitted its insureds to obtain their prescription drug requirements from KMSB or KBPI upon payment of a $1.00 or a $2.00 co-pay for each prescription. During weekends and after 6:00 p.m. the insured would be indemnified for purchases from community pharmacies of

prescription requirements. In addition, under the major medical coverage of this policy, the insured was indemnified for eighty percent (80%) of all medical expenses, including prescription drugs, once a nominal deductible had been satisfied. Under this provision, the insured was indemnified from the cost of having prescriptions filled at any community pharmacy.

The second policy included major medical coverage and a basic benefit package. The basic benefit coverage contained no pharmacy benefit. Indemnity for pharmaceutical expense was covered solely under the major medical provisions, after satisfying a nominal deductible, i.e. $50.00 for all medical expenses incurred during a year.

The first two types of policy were written on a group basis. A third form of policy, identical in form and in substance

to the second, was made available solely to individuals. Finally, the fourth form of policy is a Medicare supplement. It provides the insureds no coverage against the risk of incurring prescription drug costs (CR 51).

Prior to 1969 there was but one corporation. It was known as KMSB, a for-profit corporation. In 1969 a new corporation was formed. It is a non-profit corporation. It was formed to conduct the business of insurance under the auspices of ORS 750 *et seq.* It acquired the name "KMSB" from the for-profit corporation. The for-profit corporation then assumed the name KBPI. KBPI remained in business to liquidate various hospital assets and to continue the pharmacy operation which had been located within one of the hospitals.

Between 1969 and 1976, when KBPI was dissolved, it agreed to furnish insureds of KMSB with some of their requirements of

prescriptive drugs pursuant to a provider agreement with KMSB.

After July 1, 1976, KMSB furnished the drug benefit from its *own* dispensing facility. If an insured purchased the form of policy containing a pharmacy benefit as part of its basic provisions, the insured had a variety of options. If he or she chose to purchase prescription drugs on the weekend or after the KMSB facility was closed from a community pharmacy, the insured would be indemnified by KMSB. If the insured had satisfied the nominal deductible which triggered the coverage of the major medical provisions of the policy, then KMSB would indemnify its insured for 80% of the cost to purchase drugs from a community pharmacy. Alternately, such an insured could, after payment of a $2.00 co-pay, utilize KMSB the pharmacy.

Until August, 1976, KBPI was the sole location where an insured could utilize the

basic benefits of his prepaid medical program, except, as indicated above, after hours, weekend, or out-of-area needs. However this limitation was due solely to the inability of KMSB and the community pharmacy to reach agreement.

In August, 1974, there was discussion whether to permit other community pharmacies to participate in the KMSB basic benefits prepaid pharmacy program. KMSB offered all community pharmacies the same arrangement which KMSB had with KBPI. This would provide eligible subscribers with drugs at pharmacy cost plus 10%, less the service fee (CR 90).

In September, 1974, Mr. Dicken, executive director of KMSB, had a conversation with Mr. Gion, the representative of the community pharmacies. Mr. Gion stated a concern about determination of cost; about the amount of

reimbursement to be granted; and about determination of insured eligibility.

In consequence of these discussions, on October 2, 1974, Mr. Dicken advised the local pharmacies that, because of administrative costs, KMSB was not prepared to amend its policy of insurance to include additional prescriptive drug outlets within its basic policy (CR 90). This statement did not terminate discussions.

On December 17, 1974, the Board of KMSB met with three local pharmacists representing other community pharmacies. A discussion ensued regarding the pharmacy benefit and the implications, including costs, of opening up the basic drug benefit to other pharmacies. No definite decision was made by either group. The pharmacists stated they would discuss the matter with their constituency and report back. KMSB stated that it would refer the matter to

its Consumer Advisory Committee for comment (CR 90).

On January 16, 1975, Robert Gion wrote to KMSB and advised that its members were prepared to fill the entire KMSB insurance prescription needs on the following basis: Average wholesale price plus $2.50, less the $1.00 co-pay. Eligibility would be determined by membership card and a cancellation sheet from the office of KMSB. It further agreed to "police our own group" where necessary, which presumptively meant dealing with abuses (Tr. 90).

At the meeting of KMSB on January 31, 1975, Mr. Dicken reported receipt of the proposal. He advised that the proposal was the equivalent of the Blue Cross Plan. He projected at that time that there would be a probable full 3% increase in cost if the proposal were accepted (CR 46; Ex. 3).

At the February 18, 1975 Board meeting of KMSB, there was a lengthy discussion

about the pharmacy benefit. Members of the Consumer Advisory Committee were present. They are people who are representatives of insured members of the Plan. The Consumer Advisory Committee stated that it felt the present prescription drug program was adequate and that every effort should be made to keep premiums to an absolute minimum (CR 90; CR 46, p. 92). At the March 18, 1975 Board meeting of KMSB it was resolved that the basic benefit program should not be open to other prescriptive outlets because of the substantial additional cost entailed.

SUMMARY OF ARGUMENT

The decision by the Ninth Circuit Court of Appeals is consonant with this Court's decisions in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) and *St. Paul Fire & Marine*

Insurance Co. v. Barry, 438 U.S. 531, 98 S. Ct. 2923 (1978); not in conflict with the Fifth Circuit decision in *Hyde v. Jefferson Parish Hospital District No. 2*, 686 F.2d 286 (5th Cir. 1982), *cert. granted* March 7, 1983, Docket No. 82-1031; does not conflict with other decisions of the Ninth Circuit; and furthers the public policy embodied within the antitrust laws.

ARGUMENT

The Opinion Here Does Not Conflict With Decisions of This Court.

A.

Association contends that the decision of the Ninth Circuit is in conflict with this Court's holding in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). The contention is frivolous. In *Royal Drug Co.* the issue was whether an agreement between an insurance carrier and

various pharmacies constituted the business of insurance. The court held that provider agreements do not constitute the business of insurance because they did not involve the underwriting or spreading of risk.

Consistent with the teachings of this decision, neither KMSB nor KBPI contended that the provider agreement between the two of them was sheltered by the McCarran-Ferguson Act from scrutiny under the antitrust laws. To the contrary, KMSB contended that only its policy of insurance with its insureds was exempt. By definition the policy, defining covered risks, involves the underwriting and spreading of risk.

B.

The Association contends that the holding of the Ninth Circuit is inconsistent with this court's decision in *St. Paul Fire & Marine Insurance Co. v. Barry*, 438 U.S. 531 (1978). More specifically, it

contends that the activities of KMSB constituted a form of boycott in contravention of the proviso to the McCarran-Ferguson Act.

St. Paul Fire & Marine Insurance Co. v. Barry, supra, involved a conspiracy among a group of medical malpractice insurers to compel insureds to deal solely with one carrier. The court was careful to note that the boycott

> "* * * went well beyond a private agreement to fix rates in terms of coverage, as it denied policyholders the benefits of competition in vital matters such as claims policy and quality of services * * *."

Further, the court stated that the conduct of the defendant occurred outside of any regulatory arrangement established under the laws of the state of Rhode Island and could not be said to have been authorized or required by the state.

There are three salient distinctions between this case and *Barry*. First, the purported boycott arises out of the terms of the insurance policy[1]. The Association quarrels with the coverage limitations and not with some extrinsic conduct. The policy was submitted to the Insurance Commissioner of the state of Oregon; its terms were tested against the regulatory mandate of ORS 743 *et seq.*; its terms were held consistent with the regulatory scheme and therefore appropriate for issuance to the public.

Second, this is not the type of conduct which Congress had in mind in enacting the proviso to the McCarren-Ferguson Act. The decision whether and to what extent to underwrite a

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[1] It must be recognized that KMSB did not contend that its provider agreement with KBPI was protected under the McCarren-Ferguson Act.

specific risk is not what Congress had in mind in deploying the term "boycott".

Finally, even under the most expansive of definitions, the activities of KMSB did not constitute a boycott. Its insureds were given freedom of choice with respect to the type of policy to purchase. They could purchase either with or without the basic pharmacy benefit. If they chose to purchase without the basic pharmacy benefit, they were entitled to receive indemnity for purchases from community pharmacies after satisfying a nominal deductible. If they elected to purchase the form of policy with basic pharmacy coverage, insureds were free to purchase from community pharmacies, at their own expense; to purchase from community pharmacies after hours, on weekends, and when out of area; and to purchase from community pharmacies after satisfaction of the deductible. At best, it can be stated

that KMSB offered an attractive insurance policy which sold well. This is not a boycott.

Finally, KMSB granted members of the Association an opportunity to participate. Their response was to offer to participate only under terms more favorable to them. This is not the stuff out of which boycotts are made.

C.

The Association asserts that the Ninth Circuit "weighed" the evidence; and that such conduct contravenes the standards established by *Poller v. Columbia Broadcasting System, Inc.*, 368 U.S. 464 (1962) and by the Seventh Amendment.

The Ninth Circuit, when considering the purported "attempt to monopolize" claim for relief, stated that there was an insufficiency of evidence from which to find the existence of either the requisite intent or predatory conduct.

There is no suggestion that the Ninth Circuit "weighed" the evidence. Rule 56(c) requires that the target of a motion for summary judgment

> "* * * not rest on the mere allegations or denials of his pleadings, but his response, by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial."

After the defendants' moving papers demonstrated the lack of any genuine fact dispute, the Association failed to identify any controverting evidence. *See Harold Friedman, Inc. v. Kroger Co.*, 581 F.2d 1068 (C.A. Pa. 1978); *Murdock v. City of Jacksonville, Florida*, 361 F. Supp. 1083 (D.C. Fla. 1973).

This court in *First National Bank of Arizona v. Cities Service Co.*, 88 S. Ct. 1575, 1592, 391 U.S. 253 (1968) enunciated the standards applicable to Rule 56. It stated:

> "* * * all that is required is that sufficient evidence supporting the claimed factual dispute be shown to require a jury or judge to resolve the parties' differing versions of the truth at trial. * * *."

The Ninth Circuit found such evidence had not been produced. The Association identfied no such evidence here.

There Is No Intra-Circuit Conflict On The Tying Issue.

The Association asserts that the decision of this Court conflicts with *Hyde v. Jefferson Parish Hospital District No. 2*, 686 F.2d 286 (5th Cir. 1982), *cert. granted* March 7, 1983, Docket 82-1031. There is no such inconsistency.

In *Hyde*, the hospital entered into a contract with a group of anesthesiologists. The contract granted the group of anesthesiologists exclusive right to furnish anesthesiology services within the hospital. The Fifth Circuit held this arrangement to be an unlawful tying. It

found the tying product to be the services of the hospital generally and the tied product to be the provision of anesthesiology services.

The Association here asserts two discrete tying arrangements. The first is that KMSB tied the general terms and benefits of the health care insurance contract to the pharmacy benefit. The second is a tie between the pharmacy benefit and the restrictions on the sources from which the drugs could be purchased.

The Ninth Circuit found it unnecessary to determine whether the relationship between the general terms of the health care contract and the pharmacy benefit constituted an unlawful tying arrangement because it held that the terms of an insurance policy are protected from antitrust scrutiny by reason of the McCarran-Ferguson Act. As such, the holding in *Hyde* was not implicated.

The second tying theory, the purported linkage of the pharmacy benefit to the requirement that drugs be dispensed by KBPI, fails for a variety of reasons. First, as the Ninth Circuit correctly pointed out, there is but a single product involved (App. 20-22A). Second, the insured was given the right to chose between forms of insurance policy. Third, there was no coercion, express or implied, to purchase both products. *Hirsh v. Martindale-Hubbell, Inc.*, 674 F.2d 1343, 1346-47 (9th Cir.), *cert. den.* 103 S. Ct. 305 (1982).

In *Hyde* the parties never seriously questioned whether there were two products. Further, the consumer had no freedom of choice at the inception of the relationshp. For these reasons the *Hyde* case is factually and conceptually distinguishable.

There Is No Inter-Circuit Conflict.

The Association asserts that the Ninth Circuit's decision here was inconsistent with its decision in *Portland Retail Druggists Association v. Kaiser Foundation Health Plan*, 662 F.2d 641 (9th Cir. 1981); *United States v. Title Insurance Rating Bureau of Arizona*, 700 F.2d 1247 (9th Cir. 1983); and *Hahn v. Oregon Physicians Service*, 689 F.2d 840 (9th Cir. 1982), *cert. den.* The Association's contention is not sustainable.

In *Portland Retail Druggists Association v. Kaiser Foundation Health Plan*, 662 F.2d 641 (9th Cir. 1981), the issue was whether "appellants could prove any set of facts under the pleadings which would state a Section 1 tying claim." After review of the pleadings, the court concluded:

> "We therefore cannot agree that under no set of facts could they prove illegal tying."

This conclusion is distinguisable in two ways from the present case. First, the Ninth Circuit, in *PRDA v. Kaiser*, failed to decide whether the conduct of the defendant was exempt under the McCarren-Ferguson Act as the Court here did. As the Ninth Circuit confirmed, it had not previously considered the issues presented in this case, "it thus far skirted the issues in other situations" *Portland Retail Druggists Association v. Kaiser Foundation Health Plan*, 662 F.2d 641 (9th Cir. 1981), (App. 14A). Second, the evidence demonstrates that the insured here was free to pick and chose health plans, only one of which included the basis benefits drug plan.

In *United States v. Title Insurance Rating Bureau of Arizona*, 700 F.2d 1247 (9th Cir. 1983) suit was filed by the United States against the Title Insurance Rating Bureau of Arizona for fixing the

price of escrow services. The issue presented in the case was whether the provision of escrow services by title insurers was part of the "business of insurance" exempt from the Sherman Act by the McCarran-Ferguson Act.

The Court analyzed the activities of the defendant in line with the *Pireno*[2]-*Royal Drug* requirement. It found that the activities were not related to the transfer or spread of risk; that they were not an integral part of the policy relationship between the insured and the insurer; and that they involved individuals outside the business of insurance.

Here the Association claims arise out of the agreement between the insured and the insurer; they involve the transferring

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[2]*Union Labor Life Insurance Company v. Pireno*, ___ U.S. ___, 102 S. Ct. 3002 (1982).

and isolation of risk; and are confined to entities within the insurance industry.

The factual differences between decisions in *United States v. Title Insurance Rating Bureau of Arizona* and this case produced different holdings. This does not establish the existence of a conflict within the circuit because the legal principles enunicated in these cases were consistent.

Finally the Association asserts a conflict between this decision and *Hahn v. Oregon Physicians Service*, 689 F.2d 840 (9th Cir. 1982), *cert. den.* This same assertion was made by the appellants in the petition for certiorari in the *Hahn* case and apparently found an inadequate predicate to grant of certiorari. Further, the facts in the *Hahn* case are markedly different than those present here.

The Judgment Is Consistent With Public Policy.

The policies in issue in this case grant a choice to the consumer. Consumers are free to purchase a policy providing a pharmacy benefit as part of its basic provisions; to purchase a policy with a pharmacy benefit as part of its major medical provisions; to purchase no policy from this defendant; to purchase no policy of insurance at all; or to purchase from some other insurer. There is no frustration of consumer free choice.

There may have been some adverse impact upon members of the Association. When proffered an opportunity to participate as a provider in 1974, they rejected the opportunity and demanded a greater price than had been paid to KBPI. It is not a policy of the antitrust laws to reward those who would refuse to compete on an equal basis. Further, Association

members were the beneficiaries of the very policies of insurance of which they complain to the extent that insureds elected to use community pharmacies on weekends, after hours, and pursuant to the provisions of the major medical feature of the contract. In consequence the activities of the defendants were wholly consistent with the purposes and the goals of the Sherman Act.

CONCLUSION

Defendants respectfully submit that Association's petition for writ of certiorari should be denied.

Respectfully submitted,

SCHWABE, WILLIAMSON, WYATT,
MOORE & ROBERTS

By: _____
Thomas M. Triplett
Counsel for Respondents

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

KLAMATH-LAKE PHARMACEUTICAL ASSOCIATION, an Oregon non-profit corporation, on behalf of its assignors, Plaintiff-Appellant, vs. KLAMATH MEDICAL SERVICE BUREAU, an Oregon non-profit corporation, and KLAMATH BUREAU PHARMACY, INC., a now dissolved Oregon profit corporation, Defendants-Appellees.	FILED March 4, 1983 Clerk U. S. Court of Appeals OPINION No. 81-3608 CV 78-868-S0

Appeal from the United States District Court
for the District of Oregon
Gus J. Solomon, District Judge, Presiding
Argued and Submitted August 4, 1982

Before: KILKENNY, SNEED, and SKOPIL, Circuit Judges
As amended April 1, 1983

SNEED, Circuit Judge:

This appeal was filed by Klamath-Lake Pharmaceutical Association (Association), the assignee of the antitrust claims of a group of pharmacies that service the Klamath Falls, Oregon area. Association's assignors have been losing business to a local nonprofit health care provider, Klamath Medical Service Bureau (Provider), ever since it began to offer prescription drugs in kind under its group health insurance policies. Association in 1978 sued Provider and Klamath Bureau Pharmacy, Inc. (Pharmacy), a local for profit pharmacy Provider once used to distribute prescription drugs under its pharmacy benefit. The district court, after allowing Association to conduct extensive discovery, could not find any wrongdoing and dismissed

the lawsuit in a series of partial summary judgments. For the reasons stated below, we affirm.

I.
STATEMENT OF FACTS

At the time Association brought this suit, Provider offered two different group policies.[1] Both had major medical coverage and a package of basic benefits, but only one included a pharmacy benefit. This supplemental benefit, available for a higher policy premium, entitled insureds to purchase prescription drugs for a small processing fee. The nominal "copay" amount was set at one or two dollars per prescription. Provider's success in marketing its pharmacy benefit led to this lawsuit.

Until July 1, 1976, Provider supplied pharmacy benefits exclusively through Pharmacy. Provider at one point considered expanding its distribution network. Its board of directors voted at their August, 1974, meeting to invite local pharmacies to participate if they would accept reimbursement for each prescription at pharmacy cost plus ten percent, minus a copay amount of one dollar. The pharmacies' response, outlined in a letter from pharmacist Robert Gion, was to insist on receiving average wholesale cost plus $2.50 per prescription, minus the copay amount. This rate, which was modeled after Blue Cross' reimbursement policies, would have increased Provider's direct cost for most prescriptions. An expanded program would also have been more expensive to operate. Ted Dicken, Provider's executive director, estimated to the board of directors that increasing the number of participating pharmacies would result in a three percent increase in administrative costs. The board referred the question to its consumer advisory committee, which recommended that the program not be expanded on these terms. The board agreed, deciding, in Dicken's words, that "at this time it would not be feasible to open the K.M.S.B. Prescriptive drug benefit to other prescription outlets." The increase in

1. Provider's other two policies, one an individual policy and the other a group Medicare supplement, are not at issue in this lawsuit.

premiums and in administrative complexity outweighed the benefits of any added convenience to subscribers.

In 1976 Provider decided to distribute drugs directly. It bought out Pharmacy, dissolved it, and set up a pharmacy on its own premises. Thus, as of July 1, 1976, insureds with few exceptions had to get their prescriptions filled by Provider if they used the pharmacy benefit.

Competing pharmacies were not entirely cut off from business with the insureds of Provider. Groups without the pharmacy benefit had no incentive to shop at Pharmacy while it supplied drugs for Provider because it charged them full market rates. Furthermore, once Provider began to fill prescriptions, it limited sales to insureds using the pharmacy benefit. This restriction forced other policyholders, and all uninsured customers, to use the community pharmacies. The 10,000 policyholders without the pharmacy benefit were entitled to reimbursement under their major medical provision for 80% of their medical expenses, including prescription drugs, subject to a fifty or hundred dollar deductible. Their purchases constituted a substantial amount of business of the pharmacies. Even policyholders with the pharmacy benefit were free to patronize other pharmacies after hours or during holidays. Although these purchases were made at full cost, reimbursement of 100% of this cost less the copay amount was provided under the terms of the pharmacy benefit. This privilege was important because Provider's pharmacy was only open until 6:00 P.M. on weekdays and 3:00 P.M. on Saturday. Policyholders traveling outside of the Klamath Falls area, and those living in outlying communities, could also use local pharmacies and be repaid under the terms of the pharmacy benefit.

Nonetheless, Provider's prescription drug program cut substantially into the business of local pharmacies. Provider's prescriptions more than doubled between 1974 and 1978, from 33,440 to 77,541; several local pharmacies went out of business and the sales of others dropped rapidly. In response seven pharmacies assigned their antitrust claims to Association, which then brought this lawsuit.

II.
THE ISSUES ON APPEAL

Association alleged three causes of action in its complaint. First, it accused Pharmacy and Provider of receiving prescription drugs on terms unavailable to its members, in violation of the Robinson-Patman Act, 15 U.S.C. §13(f). Second, it claimed that Pharmacy and Provider conspired with affiliated physicians, public and private signatories of the group contracts, and labor unions in an attempt to monopolize and restrain trade by compelling insureds to boycott Association's members, in violation of sections 1 and 2 of the Sherman Act, 15 U.S.C. §§1-2. Third, it alleged that the insurance contracts tied the health care policy to the prescription drug benefit, in violation of section 3 of the Clayton Act, 15 U.S.C. §14.

Provider and Pharmacy answered with the affirmative defense of exemption from the antitrust laws under the McCarran-Ferguson Act, 15 U.S.C. §§1011-1015. Association sought summary judgment on this issue in March, 1979. The district court agreed to strike the defense as it affected the agreement between Provider and Pharmacy.[2]

In October, 1979 Provider filed for partial summary judgment asserting that the McCarran-Ferguson Act shielded it from both the charges of tying and those parts of the boycott claim that rested on the health insurance contract between Provider and its insureds. The court agreed.

This left for resolution only the Robinson-Patman charge and the boycott claim as it applied to Provider's agreement with Pharmacy. Provider and Pharmacy moved for summary judgment on these remaining claims in August 1981. They sought, in the alternative, dismissal of the action

2. This motion was granted on stipulation, with Pharmacy and Provider free to renew the defense for the provider agreement if the Ninth Circuit later found a claim of exemption available in the aftermath of Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979). Such a defense has not become available. *See* Portland Retail Druggists Ass'n v. Kaiser Found. Health Plan 662 F.2d 641, 647 (9th Cir. 1981).

under Fed. R. Civ. P. 17(a) because Association was not a real party in interest. They also argued that the assignments did not convey all of the assignors' claims. The district court granted the motion to dismiss. Because of the likelihood of appeal, it went on to reach the merits of the remaining issues. It held for the defendants on these as well. The Robinson-Patman claim fell because Association had turned up only one minor price variation in the thousands of invoices it reviewed during discovery. The court then summarily denied the residual boycott and tying claims.[3] Association appealed.

The issues that must be considered by this court are as follows. First is the validity of the assignments. If Association cannot act as assignee, this appeal must be dismissed. Next are the major substantive problems: the merits of the Robinson-Patman claim, the affirmative defense based on the McCarran-Ferguson Act to the tying and boycott claims, and the merits of these two claims. Last is Association's argument that the district court should have allowed it to amend or supplement its claim. After considering briefly the use of summary judgment in antitrust cases, we will address these issues in order.

III.
SUMMARY JUDGMENT AS APPLIED TO ANTITRUST CASES

Summary judgment, dependent as it is on the absence of a "genuine issue as to any material fact," requires an assessment of evidence regarding issues of material fact in the light most favorable to the party opposing the motion to grant such judgment. *ILGW v. Sureck*, 681 F.2d 624, 628-29 (9th Cir. 1982); *Heiniger v. City of Phoenix*, 625 F.2d 842, 843 (9th Cir. 1980). Summary judgment traditionally has been used sparingly in antitrust litigation because of the factual intricacy of many antitrust issues. *See Poller v.*

3. As we read the district court's earlier amended opinion, it had in fact already disposed of the tying claim in full. The meaning of its amended opinion is discussed in notes 13 & 15 *infra*.

Columbia Broadcasting System, Inc., 368 U.S. 464, 473 (1962). At the same time, however, antitrust litigation, if made immune from summary judgment, could become an anticompetitive activity itself. For example, a losing competitor could employ an antitrust suit to harass its victorious opponent. So employed the antitrust laws would impose unwarranted economic costs on the marketplace. Thus, to keep these costs in check we should use summary dispositions to dispose of antitrust complaints that lack any significant supporting evidence. *See, e.g., First National Bank v. Cities Service Co.*, 391 U.S. 253, 289-90 (1968); *Betaseed, Inc. v. U & I, Inc.*, 681 F.2d 1203, 1207-08 (9th Cir. 1982). Our analysis in this case is guided by these principles.

IV.
THE VALIDITY OF THE ASSIGNMENT TO ASSOCIATION

The district court found that Association was not a real party in interest as required by Rule 17(a), but was merely a nominal party which should not have been allowed to prosecute this action. It reached this result because, in its view, the assignors "retained their interest in the outcome of the litigation." Association's request for treble damages for the assignors was taken as an indication that no true transfer of claims had occurred.

The district court erred. An assignment of claims does not prevent the assignors from receiving the benefits of the litigation. *Pacific Coast Agricultural Export Association v. Sunkist Growers, Inc.*, 526 F.2d 1196 (9th Cir. 1975), *cert. denied*, 425 U.S. 959 (1976). Thus, in *Sunkist Growers* we upheld an award of damages to fresh fruit growers in litigation brought on assignment by their trade association. *See id.* at 1200. The consideration that moved to Association in this case consists of the transfer to it of authority to bring suit and to allocate the proceeds. In exchange Association undertook to bring suit. It is not necessary that the assignors forfeit all interest in possible damages before consolidating their claims in a more efficient class suit.[4]

Rule 17(a) is designed to ensure that lawsuits are brought in the name of the party possessing the substantive right at issue. *See* 6 C. Wright & A. Miller, *Federal Practice and Procedure* § 1541, at 635-36 (1971 & Supp. 1982). It is not to prevent a consolidation of individual claims such as occurred here.

The district court also found the transfer of Clayton and Robinson-Patman Act claims ineffective because of a lack of specificity in the assignment. Whether this is correct presents a question of law reviewable de novo by this court. *Maykuth v. Adolph Coors Co.*, No. 81-3152, slip op. at 4848 (9th Cir. Oct. 19, 1982); *Martin v. United States*, 649 F.2d 701, 703 (9th Cir. 1981); *Kittitas Reclamation District v. Sunnyside Valley Irrigation District*, 626 F.2d 95, 98 (9th Cir. 1980), *cert. denied*, 449 U.S. 1079 (1981). Because there are no disputed factual circumstances, this issue is also ripe for summary disposition.

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4. The cases cited by Provider to challenge the assignment involve defects in the party bringing suit that are not present in this case. In Archie v. Shell Oil Co., 110 F. Supp. 542 (E.D. La. 1953), *aff'd per curiam*, 210 F.2d 653 (5th Cir.), *cert. denied*, 348 U.S. 843 (1954), the nominal plaintiff was an unpaid yardboy for an attorney who had given him a subsequently invalidated interest in real property via a third party. The district court dismissed the "strange document," which gave the nominal plaintiff the third party's power of attorney over the interest in land and, as consideration, conveyed the interest itself, as void under Louisiana law. *Id.* at 544. California League of Indep. Ins. Producers v. Aetna Casualty & Sur. Co., 175 F. Supp. 857 (N.D. Cal 1959), did note in dictum that a suit brought by an association of insurance agents would have to be dismissed if the association were a "mere agent for collection," but it added that the association could maintain the suit as an "assignee for collection." *Id.* at 861. District Distribs., Inc. v. Heublein, Inc., 1971 Trade Cases (CCH) § 73,695, at 90,901 (D.D.C. 1971), involved an ultra vires assignment that was also void for lack of consideration and champerty. In Cordova v. Bache & Co., 1971 Trade Cases (CCH) § 73,406, at 89,651 (S.D.N.Y. 1970), the president of an association of employees in the securities industry was denied standing to maintain an action in his own name without an assignment from the employees. In the absence of similar defects, there is no need to prevent Association from bringing this lawsuit. The rule that an assignor can prosecute its case even if it must later account to the assignees for the proceeds is a seasoned part of Oregon law. *See* Hibernia Sec. Co. v. United Mfg. Co., 59 P.2d 384, 388, 154 Or. 369, 379 (1936).

We again find that the district court erred. Our task is to enforce the intent of the parties. *Sunkist Growers*, 526 F.2d at 1208. Each assignment contained three descriptions of the claims transferred. An initial paragraph described the transfer as covering all claims arising "by reason of any violation of the Sherman Antitrust Act, as amended, 15 U.S.C. §1, et seq." Association for its part promised to seek relief "under the federal antitrust laws." The paragrph following this phrase then waived the assignors' rights "under the antitrust laws to proceed as an individual named plaintiff." The district court held that the first description should be given controlling weight and be read to limit the assignment to Sherman Act claims, leaving the pharmacies free to relitigate claims under the Clayton and Robinson-Patman Acts.

We do not find this a plausible interpretation. The contract must be read as a whole. The common-sense meaning of the transfer under the Sherman Act, "as amended," when read in conjunction with Association's broad promise to pursue relief "under the federal antitrust laws" and the assignors' equally broad waiver of their rights to proceed "under the antitrust laws," is that it conveys *all* antitrust claims against Provider and Pharmacy. This is what the parties to the assignment intended. Provider has not suggested any reason for them to have intended otherwise. Association's assignors, whose interests do not diverge, understandably sought to secure more vigorous prosecution of a common opponent, and to increase the likelihood of recovery for related injuries. The added expense of separate actions on non-Sherman Act claims makes Provider's theory of reservation for later prosecution implausible. Furthermore, had the assignors sought to save their claims for later use, they would not have employed the language in question. The assignments are not exemplars suitable to guide future litigants; they are, however, adequate to effectuate a full assignment of all claims. We therefore proceed to Association's substantive claims.

V.
PRICE DISCRIMINATION IN PROVIDER'S PURCHASE OF DRUGS FROM LEDERLE

The district court found no merit in Association's complaint of price discrimination. Provider produced over 7,000 documents that covered its purchases from 1974 until mid-1979. Among these Association turned up only one instance of alleged discrimination. Provider purchased drugs from Lederle Laboratories on a ten percent volume discount during 1978 and early 1979. The discount was available to any buyer with purchases over $300. Although its members did not remember having received the offer, Association presented no other evidence of unavailability. This is not enough.

The district court was correct in holding that there was no violation. *Any* difference in the prices of similar goods is, of course, price discrimination. *FTC v. Anheuser-Busch, Inc.*, 363 U.S. 536, 549-51 (1960); *William Inglis & Sons* Baking Co. v. ITT Continental Baking Co., 668 F.2d 1014, 1040 (9th Cir. 1981), *cert. denied*, — U.S. —, 103 S. Ct. 57, 74 L. Ed. 2nd 61, (1982). To be forbidden, however, the discrimination must be *illegal*. A buyer who receives a price differential cannot be liable under the Robinson-Patman Act unless the seller is in violation of the Act as well. *Great Atlantic & Pacific Tea Co. v. FTC*, 440 U.S. 69, 75-78 (1979). Association did not prove any violation by Lederle. It offered no proof that Lederle's discount injured competition substantially. It therefore failed to make the showing required of it. *See Inglis*, 668 F.2d at 1039-40; *Janich Brothers v. American Distilling Co.*, 570 F.2d 848, 854-55 (9th Cir. 1977), *cert. denied*, 439 U.S. 829 (1978); *Texas Gulf Sulphur Co. v. J.R. Simplot Co.*, 418 F.2d 793, 806-07 (9th Cir. 1969).

Nor did Association attempt to show that Provider knowingly induced or received Lederle's discriminatory offer. 15 U.S.C. §13(f); *Automatic Canteen Co. v. FTC*, 346 U.S. 61 (1953); *J.R. Simplot*, 418 F.2d at 803-06. Construing the evidence in the light most favorable to Association, we hold that there was no Robinson-Patman violation.

Association argues that it should have been allowed additional discovery that would enable it to examine Provider's records for recent years. Provider produced documentation for its purchases through mid-1979. Some two years elapsed before the district court issued its final opinion in October 1981. In September 1981 Association filed a request to extend discovery to cover this period, complaining that "since mid-1979 Provider has engaged in a major expansion of its activities, and said expansion is highly relevant to the . . . issues raised by the pending summary judgment motion."

The district court denied the request. In doing so it acted well within its discretion. Association does not indicate what it might expect to discover. At some point, the possibility that additional investigation might turn up a real lead becomes less important than the injustice to a defendant against whom no significant evidence has been produced. We have reached that point in this case. The district court did not abuse its discretion. *See Portland Retail Druggists Association (PRDA) v. Kaiser Foundation Health Plan*, 662 F.2d 641, 646 (9th Cir. 1981); *Program Engineering, Inc. v. Triangle Publications, Inc.*, 634 F.2d 1188, 1193 (9th Cir. 1980).

VI.
THE TYING CLAIM

A. As Between The Basic Health Care Contract and the Pharmacy Benefit

We now turn to Association's allegation of tying. Association alleged a tie between "the basic prepaid health care contract, and the optional prescription drug benefit that can be obtained only if the subscriber has the basic plan." The district court rejected Association's argument because it found that both the *basic health care contract* and the *optional drug benefit contract* came within the McCarran-Ferguson exemption. We agree.

1. The business of insurance

The antitrust exemption for the "business of insurance" arose in response to the Supreme Court's decision in *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944), which overruled prior holdings placing insurance outside the reach of the commerce clause. Congress, wishing to protect the states' traditional role in the regulation of insurance and to avoid endangering the cooperative ratemaking that had played a major role in the industry's development, *see Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 217-24 (1979), quickly passed the McCarran-Ferguson Act. The Act removed the "business of insurance" from antitrust enforcement if (1) it was subject to state regulation and (2) did not amount to a boycott under the Sherman Act.[5]

The Supreme Court in *Royal Drug* excluded health insurers' agreements with third party providers from the business of insurance. Blue Shield, the defendant in *Royal Drug*, invoked the insurance exemption when a group of pharmacists challenged the administration of the pharmacy benefit in Blue Shield's health insurance policy. Blue Shield's benefit, although similar to Provider's in many respects, did not supply drugs directly to its insureds. Independent pharmacies could participate in the plan if they accepted Blue Shield's reimbursement schedule. Most pharmacies chose to participate and signed a provider agreement with Blue Shield.[6]

5. Section 2(b), 15 U.S.C. §1012(b), provides in part that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance." Section 3(b), 15 U.S.C. §1013(b), adds the qualification that "[n]othing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation."

6. Both nonparticipating and participating pharmacies brought the antitrust suit against Blue Shield. The headnotes to the Supreme Court opinion and that of the Fifth Circuit identify the plaintiffs as nonparticipating pharmacists. 440 U.S. at 205; 556 F.2d at 1375. In fact, half of the eighteen plaintiffs participated in Blue Shield's program. *see* Royal

The question before the Supreme Court was whether the exemption covered the agreements with third party providers. The Court held that it did not; provider agreements between health care insurers and participating pharmacies were not part of the business of insurance. Such agreements were subject to normal antitrust scrutiny.

The "underwriting or spreading of risk" was held to be an "indispensable characteristic of insurance." *Id.* at 212. Cost-cutting efforts pursued through such arrangements as provider agreements, however, were no different than the acts of "any enterprise with the responsibility to minimize costs and maximize profits." *Id.* at 217. Such business activities affected only the method of payment—not the spreading of risk. The provider agreements were further distinguishable from the business of insurance because they were not part of the contract between the insurer and its insureds, and because they involved the insurer's relationship with entities outside the insurance industry. *Id.* at 215-17, 231-32.

The Court applied *Royal Drug* in *Union Labor Life Insurance Co. v. Pireno*, 102 S. Ct. 3002 (1982). Pireno, a New York chiropractor, challenged an insurer's practice of conditioning reimbursement of unusually high chiropractic fees on the decision of a peer review committee staffed by the New York State Chiropractic Association.[7] The Court tested the referral policy under three requirements drawn

Drug Co. v. Group Life & Health Ins. Co., 415 F. Supp. 343, 347 (W.D. Tex. 1976), *rev'd*, 556 F.2d 1375 (5th Cir. 1977), *aff'd*, 440 U.S. 205 (1979). Their role in the case may have resulted more from a desire to hedge their bets than to correct an antitrust violation.

7. The insurer, Union Labor Life Insurance Company (ULL), would reimburse only charges it decided were reasonable and necessary, a determination in which it deferred to the committee. Pireno had once sought review of his fees voluntarily, because he believed that going directly to peer review would permit him to avoid a cumbersome substantiation process. Pireno v. New York State Chiropractic Ass'n, 650 F.2d 387, 389 n.2 (2d Cir. 1981), *aff'd sub nom.* Union Labor Life Insurance Co. v. Pireno, 102 S. Ct. 3002 (1982). His enthusiasm for the process waned when ULL began submitting his claims independently and the committee began rejecting them. *Id.*

from *Royal Drug:* (1) whether the practice transferred or spread a policyholder's risk; (2) whether it lay at the heart of the relationship between insurer and insured; and (3) whether it was limited to entities within the insurance industry. *Id.* at 3009. It held that the referral practice did not transfer risk; it merely reduced costs. The insurance policy transferred risk and was the indispensable component of insurance. Although the policy defined the burden transferred as the cost of "necessary" treatments and "reasonable" charges, standards apparently applied in practice by the chiropractors' committee, this did not make the committee's involvement the business of insurance. This involvement was "logically and temporally unconnected to the transfer of risk accomplished by ULL's insurance policies." *Id.*[8]

The Court also held that the insurer's relationship with the peer review committee failed *Royal Drug's* second and third requirements. The peer review arrangement was beyond the primary relationship between insurer and insured. *Id.* at 3009-10. Finally the peer review board was not an "entity" in the insurance industry. Its assistance in regulating fees was but cost-cutting activity. *Id.* at 3010-11.

8. The Court left the contours of its distinction unclear. It explained that the decision to honor a claim rested "entirely" with ULL. *Pireno*, 102 S. Ct. at 3010. Under this analysis, the peer review committee was only an "aid" in making this decision. It did not affect the policyholder directly because his only concern was "*whether* the claim is paid, not *why* it is paid." *Id.* (emphasis in original). But if Pireno was correct that ULL always followed the committee's decisions—an allegation the Court was to weigh most favorably to Pireno when considering ULL's motion for summary judgment—then ULL's decision "whether" to pay chiropractors would turn exclusively on the review board's actions. The questions "whether" and "why" a claim was paid would both rest with the chiropractors' association. *Compare id.* at 3011 n.8 (peer review merely ancillary to claims adjustment because non-binding, even when ULL acted on committee's advice).

2. The business of insurance exemption and tying between the basic health care contract and the pharmacy benefit

Association's tying claim, as already noted, strikes at the health care contract and the pharmacy benefit appended to it. *Royal Drug* requires that we consider the possibility that the health insurance contract here involved, even when short of a pharmacy benefit contract, does not fit the insurance exemption. 440 U.S. at 225-30 & n. 37. We have thus far skirted the issue in other situations. *See Hahn v. Oregon Physicians Service*, 689 F.2d 840, 843 n.2 (9th Cir. 1982); *Portland Retail Druggists Association v. Kaiser Foundation Health Plan*, 662 F.2d 641, 647 (9th Cir. 1981); *see also St. Bernard Hospital v. Hospital Service Association*, 618 F.2d 1140, 1144-45 & nn. 3-5 (5th Cir. 1980). We cannot do this here because Provider argues that the exemption attached to its health insurance policy and also shielded the alleged tying agreement.

We hold that it does. Our decision turns on the Supreme Court's reasoning in *Royal Drug*. The insurer-insured agreement embodied in the basic health care contract and its supplemental pharmacy benefit settles the distribution of the risk that insureds will need medical goods and services, including prescription drugs. It defines the relationship between insurer and insured; and it is limited to these two traditional factors in the insurance industry.

The Court in *Royal Drug* did observe that health insurance was not a common form of insurance in 1945, the year Congress passed the McCarran-Ferguson Act. 440 U.S. at 225-30.[9] It did not, however, exclude the business of health insurance from the exemption. All it said was "(t)his is not to say that the contracts offered by Blue Shield to its policyholders, as distinguished from its provider agreements with participating pharmacies, may not be the

9. The Court's attempt to demonstrate that the McCarron-Ferguson Congress did not consider health service plans insurance policies drew a detailed response from the four dissenters. 440 U.S. at 233 (Brennan, J., joined by Burger, C.J., and Marshall & Powell, JJ.).

'business of insurance' within the meaning of the Act." *Id.* at 230 n.37.

We do not believe that the Court intended to remove the business of health insurance from the McCarran-Ferguson exemption. Had it so intended its detailed analysis of the limits of the insurance exemption in *Royal Drug* would have been unnecessary. Nor does *Pireno* suggest otherwise. There both the majority and the dissenters discussed the health care policies without once suggesting that the business of health insurance was not included in the business of insurance. Although the insurer was a traditional insurer, not, as in this case, a health care provider, this should not be determinative. It is the business of insurance, not merely the business of traditional insurers, that activates the exemption. *See id.* at 217, 99 S. Ct. at 1076, *quoted in Pireno*, 102 S. Ct. at 3008, 3010.

Isolation of risk distribution as the primary characteristic of the business of insurance also weighs against limiting that business to risks being shifted by traditional insurers in 1945. It is the actuarial uncertainty inherent in projecting risks and the insurance industry's corresponding need for cooperation that makes its exemption from the antitrust laws appropriate. *See Royal Drug*, 440 U.S. at 221-22. Health insurance also has these characteristics. The business of insurance, within the meaning of the McCarran-Ferguson exemption, should not be closed to policies that shift risks not ordinarily so shifted in 1945. Thus, Provider's policies with its insureds, insofar as they shift the risks of medical costs, including pharmacy costs, fully qualify as the business of insurance.

3. The state regulation requirement

Having settled that Provider's policies, insofar as they shift the risks of medical and pharmacy costs, partake of the business of insurance, we must next determine whether these policies were subject to state regulation. 15 U.S.C. §1012(b). We hold that they were. Oregon unquestionably regulated health insurance policies. Specific regulations for

health care service contracts were included in the Insurance Code, Or. Rev. Stat. §§750.005-340 (1981), as were guidelines for group health insurance, *id.* §§743.522-558. More generally, the State authorized the Insurance Commissioner to issue regulations banning "any unfair or deceptive act or practice," *id.* §746.240, and directed insurers to refrain from "anything which is detrimental to free competition in the business or injurious to the insuring public," *id.* §746.160(3). It specifically prohibited abuses like rate control, *id.* §764.160(1), and those tying practices that it found undesirable, *see id.* §746.130 (prohibiting insurers from tying sale of property or real estate). Furthermore, insurers were subject to state antitrust regulation to the extent free of state insurance regulation. *Id.* §646.740(4).

This meets the McCarran-Ferguson requirement that the state regulate the challenged activity. *See Addrisi v. Equitable Life Assurance Society of the United States*, 503 F.2d 725, 727-28 (9th Cir. 1974), *cert. denied*, 420 U.S. 929 (1975).[10]

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10. Unless the practice amounts to a boycott, the states are free to regulate it or choose not to regulate. They do not have to expressly authorize a specific activity, or proscribe it, for the exemption to apply. *Addrisi*, 503 F.2d at 728. It is enough that a detailed overall scheme of regulation exists. *Id.; see, e.g.*, Freier v. New York Life Insurance Co., 679 F.2d 780, 782 (9th Cir. 1982). Our opinion in United States v. Crocker Nat'l Corp., 656 F.2d 428 (9th Cir. 1981), *cert. granted sub nom* BankAmerica Corp. v. United states, 102 S. Ct. 2294 (1982), did not narrow this requirement. *Crocker* indicated only that regulation of interlocking directorates among insurance companies would not be construed to protect interlocking directorates between insurance companies and banks. We did state that the "most obvious reason for rejecting a claim of immunity is the absence of any state law regulating the challenged activity." *Id.* at 452. It is wrong to read this, as did the Court of Appeals for the District of Columbia in Proctor v. State Farm Mut. Auto. Ins. Co., 675 F.2d 308, 317 n.17 (D.C. Cir.), *cert. denied*, 103 S.Ct. 86 (1982), to require that a regulation specifically affect the challenged practice for it to be exempt. *Crocker* only applies in the absence of any *general* scheme of regulation governing insurers' corporate interlocks with banks. We distinguished cases where, as here, a general system of regulation might imply an affirmative decision to allow the behavior not specifically prohibited. 656 F.2d at 453 n.88. Thus *Crocker* did not narrow the general language in *Addrisi*. *See id.*

4. *The boycott exclusion*

The shelter of the exemption does not extend to practices amounting to a boycott under 15 U.S.C. §1013(b). This requirement, however, does not stand in the way of an exemption for Provider's policy. The definition of a boycott for purposes of the McCarran-Ferguson exemption is set forth in *St. Paul Fire & Marine Insurance Co. v. Barry*, 438 U.S. 531 (1978). *St. Paul* rejected prior definitions that restricted the scope of the term to boycotts among insurers and agents, *see, e.g., Addrisi*, 503 F2d at 728-29. The Court held that the boycott exception should take its broad Sherman Act meaning. Thus, boycotts were not merely limited "to concerted activity against insurance companies or agents or, more generally, against competitors of members of the boycotting group," but extended to refusals to deal with customers of some or all of those engaged in the boycott. 438 U.S. at 552.

To foreclose an exemption for Provider's health insurance policies, however, Association had to prove that the policies constituted an "agreement to boycott, coerce, or intimidate." This it has not done. Association asserts that the conspirators induced policyholders to boycott the local pharmacies by the "effective economic compulsion" derived from its pharmacy benefits. It is true that Provider offered an effective economic inducement for customers to buy drugs from it. And it is undisputed that policyholders who had chosen the pharmacy benefit had to patronize Pharmacy and, later, Provider's on-premises pharmacy to use the benefit.[11] Reimbursement for after-hours and

11. Provider claimed that these insureds could also buy prescriptions under their major medical plan. For those making numerous purchases of low-priced drugs, it could be cheaper to pay 20% of drug charges and the deductible, as the major medical required, rather than the copay charge of one or two dollars for every purchase under the pharmacy benefit. Association reads Provider's policy to prohibit those with the pharmacy benefit from getting prescription reimbursement under any other provision. This was a major issue throughout this litigation. Although we find Provider's reading of its contract fully credible, we are unwilling to reject Association's further argument that the deductible amount was a sufficiently effective deterrent to prevent the major

emergency prescriptions purchased elsewhere probably did little to diminish the appeal of Provider's pharmacy benefit. But this does not establish that the health insurance policies implemented a boycott. Insureds remained free to purchase drugs from Association's members if they chose to do so. Provider offered to the public an attractive package which sold well to the detriment of Association's members. The package is part of the many changes affecting the delivery of health care in our time. We are not prepared to hold that the package should be banned from the marketplace by the antitrust laws. Only such a holding would yield the result the plaintiff seeks.

Such a holding would be particularly inappropriate in this case. Provider not only did not exclude Association's members from competing for its policyholders; it also gave them a chance to join the business. Their response was to offer to participate only under the terms more favorable to them. When this was rejected they chose to sell less at a higher price rather than more at a lower price. They are entitled to make that choice. They are not entitled to employ the antitrust law to obtain the market position that will produce both greater sales and higher prices.

Thus, we agree with the district court that the health care policy between Provider and its insureds constituted part of the business of insurance; that Provider was regulated by the State of Oregon; and that its pharmacy benefit did not embody a boycott of Association's members. The tying claim, resting as it does on the agreements in the policy, accordingly must fail.[12]

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medical policy from being fully substitutable for the pharmacy benefit. As we find no merit in Association's claims, our decision does not turn on the question whether the major medical provisions further weakened Association's charges that the pharmacy benefit created an "effective boycott" of its members.

12. Association's argument that Provider's nonexempt involvement with Pharmacy barred it from receiving the protection of the exemption for its other activities is frivolous. Were that the case, every insurer with a provider arrangement (as in *Royal Drug*) or consultative relationship with third-parties (as in *Pireno*) would forfeit all of its exemption from the antitrust laws. The business of noninsurance would overwhelm the business of insurance. There is no support for this position in law or logic.

B. As Between the Pharmacy Benefit And The Restrictions On The Sources From Which Drugs Can Be Purchased

Association had two tying theories. The first, as already demonstrated, alleged a tie between Provider's standard health policy and the pharmacy benefit addition. The second is more nebulous. Association's initial complaint read as follows:

> A Provider subscriber desiring a prescriptive drug benefit was and is compelled to purchase the benefit as part of a Provider health care policy that "ties" said benefit to purchase of prescription drugs under the policy to a Provider-designated pharmacy and forbids the subscriber, at the risk of losing the benefit, from obtaining prescription drugs under the policy from any competitor of a Provider-designated pharmacy.

The district court took the mention of the designated pharmacy to raise, in addition to the tie in the insurance policy, a tie based on Provider's agreement with Pharmacy. The court summarily rejected the claim.[13] We agree. The provider arrangement did not tie purchase of one product to purchase of another.

However, Association may also seek to allege a tie between the pharmacy benefit and its restrictions on the sources from which drugs may be purchased. As Association stated in its Amended Motion for Partial Summary Judgment, "The two products are an insurance benefit covering prescription drugs and the form in which that benefit is to be provided."

13. The court first granted partial summary judgment under the McCarran-Ferguson Act for Provider on the tying claim only "for those violations which are based on a contract between Provider and its insureds." It left out any claim based on the contract between Provider and Pharmacy. It then amended its opinion, apparently to include the full tying claim in its disposition. *See supra* note 15. Yet in its final opinion the court went to the merits to decide that the provider agreement was not a tying agreement. As we find no support for a tying claim predicated on the provider agreement, we need not decide whether the court intended to dispose of it under the McCarran-Ferguson Act.

Interpreting Association's claim to rest on a tie between the pharmacy benefit and the drug purchase restrictions does not change the outcome. This "tying agreement," linking the pharmacy benefit set forth in the policy and the requirement that drugs be purchased from Provider or Pharmacy, fails for the fundamental reason that it does not implicate two different products.

To prevail on a tying claim, whether under section 1 of the Sherman Act, 15 U.S.C. §1, or section 3 of the Clayton Act, 15 U.S.C. §14, a plaintiff must first identify a tie between separate products. *Hirsh v. Martindale-Hubell, Inc.*, 674 F.2d 1343, 1346-47 (9th Cir.), *cert. denied*, 103 S. Ct. 305 (1982); *Hamro v. Shell Oil Co.*, 674 F.2d 784, 787 (9th Cir. 1982); *Krehl v. Baskin-Robbins Ice Cream Co.*, 664 F.2d 1348, 1352 (9th Cir. 1982). Separateness is determined in part by whether the products are normally sold or used as a unit, and whether their joint sale effects savings beyond those of combined marketing. *Siegel v. Chicken Delight, Inc.*, 448 F.2d 43, 48 (9th Cir. 1971), *cert. denied*, 405 U.S. 955 (1972) (describing the "function of the aggregate" test). The critical factor is the extent to which a producer's offerings are in response to independently structured consumer demand. Products that function together and are sold in combination may still be "separate" if consumers would prefer to buy them individually at the price necessary to market them separately. Tying denotes illegal coercion: "Rules governing tying arrangements are designed to strike, not at the mere coupling of physically separable objects, but rather at the use of a dominant desired product to compel the purchase of a second, distinct commodity." *Id.* at 47 *(citing Times-Picayune Publishing Co. v. United States*, 345 U.S. 594, 614 (1953)).[14]

14. That the product determination hinges on market demand is perhaps clearest in the trademark cases. If consumers seek only the general services of the franchisees, a franchisor cannot tie its trademark to purchase of component goods used in operating franchises. In this "business format" system, consumers "have no reason to associate with the trademark." *Baskin-Robbins*, 664 F.2d at 1353 (discussing *Chicken Delight*). Because franchisees can satisfy consumer demand by using "commonplace" items and applying the franchisor's general methods,

Whether a producer's combined products should be considered as separate can be decided only by looking at consumer behavior. It is the relationship of the producer's selling decision to market demand, not the physical characteristics of the products alone, that determines the existence of legally separable products.

There was no separation between the pharmacy benefit and the restrictions on the sources from which drugs can be purchased on these principles. Insureds, the consumers, certainly did not consider these as two separate products. In deciding whether to buy the pharmacy benefit, they made just one decision, comparing the expected cost of the benefit plus copayments for drug purchases against the expected cost of drugs bought at the independent pharmacies. The risk insureds sought to transfer was the risk of high pharmacy bills. The product these consumers sought was a means by which they could satisfy their drug needs on favorable terms. Their purchase of drugs in the required manner was the consummation of the pharmacy benefit, not an unwanted and unnecessary product tied to the desired product.

To treat the pharmacy benefit as separate from the drug purchase provisions makes no more sense than treating a contract granting an option with respect to an item as a product distinct from that consisting of the terms on which the option is to be exercised. The entire option is one product.

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coerced purchase of supplies from the franchisor forces consumers to pay for component products they don't really want. The coerced purchase of supplies thus can only have an anticompetitive motive. *Id.* In a "distributor" franchise, on the other hand, consumers are drawn to the franchise because its trademark indicates the availability of the franchisor's quality component products. "The franchised outlets serve merely as conduits through which the trademarked goods of the franchisor flow to the ultimate consumer." *Id.* To prevent the franchisor from forcing franchisees to use only company products would prevent consumers from affecting their market choices. The legality of the franchise arrangement thus turns on the court's prerception of its place in consumer demand. *See generally* Hamro v. Shell Oil Co., 674 F.2d 784, 787-88 (9th Cir. 1982).

This conclusion is not at odds with the Supreme Court's functional division of Provider's role into risk distribution and cost reduction. Provider performed both functions with one product. It differs not from an offer to perform garden maintenance. To maintain a garden requires many tasks of a different nature. The offer, however, is of a single product.

Nor does the split payment for the benefit, requiring an initial premium and then a copayment with each purchase, indicate two products. Copayment's purpose, whatever it might be, does not split the drug purchase terms of the pharmacy benefit from the pharmacy benefit itself. It functions no differently than would a provision in the offer to perform garden maintenance that required the owner of the garden to supply the fertilizer.

No doubt some insureds would have preferred to receive cash from Provider and then to buy their drugs from Association's members had their prices been comparable to those available under the pharmacy benefit. This contingent preference does not demonstrate the existence of two products. It merely shows that Provider's pharmacy benefit product would have been less appealing had Association members' prices been lower.

In conclusion, we find no support for a second tying claim. As we stated in *Hirsh*, "rules governing tying arrangements are designed to strike solely at practices employed to impede competition on the merits." 674 F.2d at 1348. Provider did not impede, but rather stimulated, competition within the pharmaceutical market. We therefore proceed to Association's remaining charge.

VII.
THE ALLEGED BOYCOTT TO EXCLUDE ASSOCIATION'S MEMBERS FROM PROVIDER'S BUSINESS

The most favorable interpretation of Association's boycott complaint yields charges of a refusal to deal, an attempt to monopolize, and an exclusive purchasing agreement. The district court, in its amended opinion, dismissed part of this cause of action—the part that rested on Provider's contract with its insureds—under the McCarran-Ferguson Act. We have already affirmed the exemption for Provider's health insurance policies. The court later granted summary judgment against Association on the merits of the residual claims (based on Provider's contract with Pharmacy).[15] We address these next.

We find no evidence, even interpreting the record most favorably toward Association, that requires that we reverse the district court's grant of summary judgment to Provider on the merits of the boycott claim. Association treated the health insurance contract as the end product of a wide group of conspirators that included Provider, Pharmacy, affiliated physicians, public body signatories, employer signatories, and labor unions. It alleged that these conspirators, by establishing the pharmacy benefit while refusing to deal with Association's members, sought to drive independent pharmacies from the market.

Association has done little, however, to support its charges. Some evidence of concerted activity directed at the alleged victims of the boycott must be offered for the

15. The district court first granted partial summary judgment against Association on the second (boycott) cause of action. It also granted summary judgment on the third (tying) cause of action, but only for violations based on the insurance contract, not those resting on the agreement between Provider and Pharmacy. It amended its opinion to issue full judgment on the third cause of action and only partial summary judgment on the second. Nevertheless, in its final opinion the court decided on the merits those portions of both the second and third causes of action that rested on the agreement between Provider and Pharmacy. Our decision here does not turn on the scope of the McCarran-Ferguson exemption actually granted in the district court's earlier opinion.

case to survive summary judgment. The failure to meet this requirement enables us to dispose of Association's claims of a conspiracy between Provider and Pharmacy, on the one hand, and various physicians, public and private signatories of the health plan, and labor unions on the other. Association has not pursued its charges against any of the latter group. Although conspiracy sufficient to survive summary judgment may be inferred from circumstantial evidence, the plaintiff must come forward with "significant probative evidence" that supports its conclusion. *Ron Tonkin Gran Turismo, Inc. v. Fiat Distributors, Inc.*, 637 F.2d 1376, 1386 n.9 (9th Cir.), *cert. denied*, 454 U.S. 831 (1981); *Blair Foods, Inc. v. Ranchers Cotton Oil*, 610 F.2d 665, 672 (9th Cir. 1980).

The possibility of a conspiracy between Provider and Pharmacy is no better supported. Whether Pharmacy be viewed as the sole distributor of Provider's products, administering a package of benefits created by the health care provider, or as a supplier of products under contract to Provider, the arrangement constitutes a lawful scheme of vertical distribution. In the aftermath of *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977), we have established narrow grounds for imputing per se illegality to such restrictions: they must "always or almost always tend to restrict competition and decrease output [and not] 'increase economic efficiency and render markets more, rather than less, competitive.' " *Krehl v. Baskin-Robbins Ice Cream Co.*, 664 F.2d 1348, 1356 (9th Cir. 1982) *(quoting Broadcast Music, Inc. v. CBS*, 441 U.S. 1, 19-20 (1980)); *see, e.g., A.H. Cox & Co. v. Star Machinery Co.*, 653 F.2d 1302, 1305 & nn.3 & 5 (9th Cir. 1981); *Ron Tonkin*, 637 F.2d at 1381-82, 1385-88. There is no indication that the arrangement between Provider and Pharmacy would "always" have—or has ever had—the proscribed effect. Therefore, it does not constitute a per se violation of the Sherman Act.

Assocation fares no better under rule of reason analysis. Its burden below as to uncover either anticompetitive intent or specific anticompetitive effects. *A.H. Cox*, 653 F.2d

at 1306. It demonstrates neither. Provider's purpose in structuring the provision of drugs for its policyholders was to meet the terms of its policy at the least cost. Association has not shown that Provider or Pharmacy sought to injure competition in the pharmaceutical market. Provider even considered having Association's members join it; but they showed no interest in handling Provider's business at its prices.

There is also no evidence of injury to competition. Association complains of its members' business losses, but economic injury to competitors is not a per se violation of the antitrust laws. It is injury to the market, not to individual firms, that is significant. *See A.H. Cox*, 653 F.2d at 1307; *Ron Tonkin*, 637 F.2d at 1388; *Kaplan v. Burroughs Corp.*, 611 F.2d 286, 291 (9th Cir. 1979), *cert. denied*, 447 U.S. 924 (1980). A plaintiff must show that the defendant intended to or did reduce the ability of others to compete before it has shown an actionable restraint of trade. *See Knutson v. Daily Review, Inc.*, 548 F.2d 795, 803 (9th Cir. 1976), *cert. denied*, 433 U.S. 910 (1977). In an openly competitive market the inefficient fail; in a non-competitive system the efficient are precluded from competing. We cannot say that Association's members have demonstrated that they are the efficient barred from competing rather than the inefficient who have failed. To hold otherwise would require that the Provider-Pharmacy arrangement be treated as illegal per se. This we cannot do. Provider's arrangement with Pharmacy was simply an exercise of its freedom to contract with whomever it chose in order to sustain itself in the marketplace. The general freedom of a single business to select its partners has been an established part of antitrust laws since *United States v. Colgate & Co.*, 250 U.S. 300 (1919).[16]

16. This freedom extends to the manufacturer who for any lawful reason terminates one distributor or supplier and puts another in its place, even if the terminated businessman is put out of business. *See Chandler Supply Co. v. GAF Corp.*, 650 F.2d 983, 989 (9th Cir. 1980); *Las Vegas Sun, Inc. v. Summa Corp.*, 610 F.2d 614, 619-20 (9th Cir.), *cert. denied*, 447 U.S. 906 (1980); *Bushie v. Stenocord Corp.*, 460 F.2d 116, 119 (9th Cir.

Neither of the other two charges that emerges from a liberal reading of Association's boycott complaint has any validity. There is insufficient evidence of either intent or predatory conduct to support an attempted monopolization claim. *See Moore v. Jas H. Matthews & Oc.*, 550 F.2d 1207, 1219 (9th Cir. 1977); *see generally William Inglis & Sons Baking Co. v. ITT Continental Baking Co.*, 668 F.2d 1014, 1027-39 (9th Cir. 1981). As Association has not proven this charge, we need not decide whether an attempted monopolization claim resting solely on Provider's direct provision of drugs would qualify for McCarran-Ferguson exemption. Finally, as already indicated, we reject Association's argument that Provider's agreement to supply discount drugs to subscribers who would patronize its pharmacy was an illegal purchasing agreement. *See* pp. 19-20. There is no merit to any of the boycott claims.

VIII.
ASSOCIATION'S PROCEDURAL MOTIONS

Association seeks to sustain the flickering life of this lawsuit by attacking the district court's denial of its motions to amend and to supplement its complaint. The trial court did not abuse its discretion by denying these motions.

Motions to amend, we recognize, are commonly granted. Although within the trial court's discretion, leave to amend "shall be freely given when justice so requires." Fed. R. Civ. P. 15(a); *see Foman v. Davis*, 371 U.S. 178, 182 (1962); *McCartin v. Norton*, 674 F.2d 1317, 1320 (9th Cir. 1982); *United States v. Webb*, 655 F.2d 977, 979 (9th Cir. 1981); *Howey v. United States*, 481 F.2d 1187, 1190 (9th Cir. 1973). We are required to review the exercise of the trial court's discretion to deny a motion to amend strictly.

1972); *Joseph E. Seagram & Sons, Inc. v. Hawaiian Oke & Liquors, Ltd.*, 416 F.2d 71, 76 (9th Cir. 1969), *cert. denied*, 396 U.S. 1062 (1970). It easily applies to the case at hand, where Provider did not drop an old associate, but merely decided not to initiate contracts with companies that would not deal with it on acceptable terms.

Thus, where the record does not clearly dictate the district court's denial, we have been unwilling to affirm absent written findings, *Webb*, 655 F.2d at 980, and have reversed findings that were merely conclusory, *Howey*, 481 F.2d at 1190-91.

At the same time, futile amendments should not be permitted. *Foman*, 371 U.S. at 182; *Smith v. Commanding Officer, Air Force Accounting*, 555 F.2d 234, 235 (9th Cir. 1977). In this case, it is clear that Association's motion should be denied for this reason. The district court rejected the motion because it was untimely, and for "other reasons." The most important "other reason" was futility. Asked the purpose of amendment, Association's attorney could only answer vaguely that it would "bring damages up to the current" and "clarify the point" that Pharmacy was a forprofit institution. Association has not used Pharmacy's profit status to support any of its claims. And it does not have compensable damages unless it proves its case. It is clear that the district court believed that amendment on these lines could not affect the outcome of this lawsuit. We agree. We find no reason to overturn its decision.

The judgment of the district court is affirmed.

AFFIRMED.

APPENDIX B

KLAMATH-LAKE PHARMACEUTICAL ASSOCIATION, an Oregon Nonprofit Corporation, on behalf of its assignors, Plaintiff,

v.

KLAMATH MEDICAL SERVICE BUREAU, an Oregon Nonprofit Corporation, and Klamath Bureau Pharmacy, Inc., a now-dissolved Oregon Nonprofit Corporation, Defendants.

Civ. No. 78-868.

United States District Court,
D. Oregon.

Feb. 27, 1981.

OPINION

SOLOMON, District Judge:

INTRODUCTION

Plaintiff is the assignee of several pharmacies in the Klamath Falls area. In 1978, it filed this action against the Klamath Medical Service Bureau (KMSB), a nonprofit provider of health insurance and health care services, and Klamath Bureau Pharmacy, Inc. (KBPI), a nonprofit pharmacy.[1]

KMSB offers four health insurance policies. The first type provides major medical coverage with basic benefits. The basic benefits provision includes a pharmacy benefit, which permits insureds to purchase prescription drugs from the KMSB pharmacy and pay only one or two dollars for the prescription. This contribution is called a "co-pay." The major medical provision of this policy covers the insured for 80 percent of all medical expenses, including prescription drugs, in excess of $50.00 deductible. Under this provision, the insured is not limited to the KMSB pharmacy but may have prescriptions filled at any pharmacy.

1. KBPI was dissolved in 1976, and KMSB purchased its assets.

The second policy includes major medical coverage, and a basic benefit package, without the pharmacy benefit. This policy is available only on a group basis. The third policy is the same as the second, and is available to individuals only. The fourth supplements medicare coverage and offers no coverage for prescription drugs.

Plaintiff attacks the prescription drug benefit of the first policy, in three separate causes of action. In the first, plaintiff contends that KMSB purchased prescription drugs at prices and terms not available to plaintiff's assignors, in violation of the Robinson Patman Act. In the second, it contends that KMSB has created an illegal tying arrangement by including a prescription drug benefit in its insurance coverage. In the third, it contends that the prescription drug benefit violates the Sherman and Clayton Acts because it restrains KMSB's insureds from purchasing prescription drugs from plaintiff's assignors.

Defendants seek a partial summary judgment. They contend that the McCarran-Ferguson Act exempts any contract between KMSB and its insureds from the Clayton and Sherman Acts. They, therefore, assert that they are entitled to judgment on the second cause of action, and also on any of the violations charged in the third cause of action based on a contract betwen KMSB and its insureds.

McCARRAN-FERGUSON ACT

To qualify for an exemption under the McCarran-Ferguson Act, 15 U.S.C. §1011 *et seq.*, three conditions must be met. First, the anticompetitive practices must be part of the business of insurance, not merely the business of insurance companies.[2] Second, those practices must be

2. 15 U.S.C. § 1011:
Congress declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

regulated by the state.[3] Third, the anticompetitive practices must not take the form of coercion, intimidation or boycott.[4]

1. *Business of Insurance*

[1] Plaintiff contends that the prescription drug benefit included in one type of KMSB insurance policy is not the "business of insurance" under the McCarran-Ferguson Act. It cites *Group Life and Health Insurance Co. v. Royal Drug*, 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979). In that case, Blue Shield offered health insurance policies which included a prescription drug benefit. Insureds with this coverage who purchased their prescriptions from a participating pharmacy paid only two dollars for the prescription, and the pharmacy recovered its cost of the prescription from Blue Shield. But an insured who purchased a prescription from a non-participating pharmacy paid the pharmacy the full price, and would then be reimbursed by Blue Shield for 75 percent of the full price less two dollars.

Any licensed pharmacy could be a participating pharmacy, but the participating pharmacies were required to accept a two dollar mark-up on each sale. Royal Drug contended that the agreements between Blue Shield and the

3. 15 U.S.C. § 1012:
(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1980, as amended, known as the Sherman Act, and the Act of October 14, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

4. 15 U.S.C. § 1013(b):
Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

participating pharmacists violated the antitrust laws because they discouraged Blue Shield's insureds from using non-participating pharmacies. Blue Shield contended that the agreements were "the business of insurance" and were exempt from the antitrust laws under the McCarran-Ferguson Act.

The Supreme Court defined the "business of insurance" to include two critical elements: the spreading and underwriting of an insured's risk and a relationship between the insurer and the insured. *Id.* at 211 and 215-216, 99 S.Ct. at 1076-1077. The Court held that the provider agreements between Blue Shield and the participating pharmacies contained neither of these elements. First, it rejected Blue Shield's argument that the provider agreements were basic to the pharmacy benefits they offered their insureds, and held that the provider agreements "serve[d] only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations." This differed from Blue Shield's obligation "under its insurance policies, which insure against the risk that policy holder will be unable to pay for prescription drugs." *Id.* at 213, 99 S.Ct. at 1074. Second, the agreements were not between an insurer and an insured. Blue Shield was therefore not exempt under the McCarran-Ferguson Act.

Although this case, like *Royal Drug*, involves a pharmacy benefit, the two cases are distinguishable. In *Royal Drug*, plaintiffs challenged an agreement between an insurer and drug providers, and the Court held that because these agreements did not directly spread or underwrite the insured's risk of needing prescription drugs, they were not the business of insurance. Here, plaintiff challenges the pharmacy benefit in the insurance policy itself. The benefit, like other provisions in the insurance policy, spreads the risk that the insured may need the covered service among all those who pay premiums for that coverage. *Royal Drug* by its own terms does not extend to benefit provisions in the insurance policy itself. *Id.* at 213, 230 n. 37, 99 S.Ct. at 1074.

I hold that the pharmacy benefit included in KMSB's insurance policies with its insureds satisfies the "business of insurance" requirement of the McCarran-Ferguson Act.

2. *State Regulation*

[2] The second requirement of the McCarran-Feguson Act is that the business of insurance be regulated by state law. 15 U.S.C. § 1012(b).

KMSB is regulated by the Oregon Insurance Code under ORS § 750.005-.340, the provisions which cover Health Care Contractors. These sections make applicable to KMSB many of the regulations to which the business of insurance generally is subject. Section 743.006 requires insurers to submit their policy forms to the Insurance Commissioner for approval. Section 743.-009 requires the Insurance Commissioner to disapprove the policies if they do not comply with the law, are prejudicial to the insurer's policy holders, or are unjust, unfair, or inequitable. Subsection 746.160(3) forbids insurance companies from "doing anything which is detrimental to free competition in the business or injurious to the insuring public."

This regulatory scheme satisfies the second requirement of the McCarran-Ferguson Act. *Dexter v. Life Assurance Society of the United States*, 527 F.2d 233 (2nd Cir. 1975); *Transnational Insurance Co. v. Rosenlund*, 261 F.Supp. 12, 25-26 (D.Or. 1966).

[3] Plaintiff contends that the McCarran-Ferguson Act does not apply because the Oregon Insurance Code does not specifically regulate the practice of pharmacy, or the particular practices in issue here. If the state regulates the business of insurance, and the practices challenged are part of the business of insurance, the failure of the state to react to a particular practice does not affect the application of the McCarran-Ferguson Act. *Addrisi v. Equitable Life Assurance Society of the United States*, 503 F.2d 725 (9th Cir. 1974), *cert. denied*, 420 U.S. 929, 95 S.Ct. 1129, 43 L.Ed.2d 400 (1975).

3. *Boycott*

[4] Finally, plaintiff contends that KMSB's requirement that its insureds use the KMSB pharmacy to receive the pharmacy benefit amounts to a boycott, and is therefore subject to the antitrust laws under § 1013(b) of the McCarran-Ferguson Act. Specifically, plaintiff alleges that KMSB's pharmacy is in direct competition with plaintiff's assignors, and that KMSB has, with its co-conspirators, attempted to boycott, coerce, or intimidate plaintiff's assignors.[5]

To meet the boycott exception, plaintiff must show that its assignors have been boycotted because they have been denied all access to KMSB insureds who purchase prescription drugs. In *St. Paul Fire and Marine Insurance v. Barry*, 438 U.S. 531, 98 S.Ct. 2923, 57 L.Ed.2d 932 (1978), the Court found a boycott in the sale of medical malpractice insurance, because the concerted activity "foreclosed all possibility of competition anywhere in the relevant market." *Id.* at 553, 98 S.Ct. at 2935.

KMSB does not preclude its insureds from patronizing plaintiff's assignors. First, those insureds who have the pharmacy benefit also have major medical coverage, and when they have satisfied the nominal deduction, are reimbursed for prescription drug expenses without regard to the pharmacy at which they purchased the prescription. An insured may elect to use either part of his insurance coverage in claiming pharmacy benefits. The major medical coverage may be more advantageous because of the "co-pay" requirement of the pharmacy benefit. Second, even if the subscriber elects to use the KMSB pharmacy benefit, the insured may use other pharmacies in an emergency or when the KMSB pharmacy is closed, without losing the benefit.

5. Defendant's co-conspirators are identified as physicians affiliated with KMSB; public body signatories and employer signatories to KMSB contracts with prescription drug benefits; and labor unions that obtained KMSB contracts with prescription drug benefits for their members.

I hold that there was no coercion, intimidation, or boycott.

CONCLUSION

Defendants' motion for partial summary judgment is granted. Defendants are entitled to judgment on the second cause of action, and on the third cause of action for those violations which are based on a contract between KMSB and its insureds.

I leave to future proceedings plaintiff's Robinson Patman Act claims, and also plaintiff's claims based on a tying agreement between KMSB and KBPI.

APPENDIX C

CONSTITUTION OF THE UNITED STATES, AMENDMENT VII

In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law.

STATUTES

Sherman Act, Section 1, 15 U.S.C. § 1

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal: * * *.

Sherman Act, Section 2, 15 U.S.C. § 2

Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty * * *.

Clayton Act, Section 4, 15 U.S.C. § 15

Any person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor in the district court of the United States in the district in which the defendant resides or is found or has an agent, without respect to the amount in controversy, and shall recover three-fold the damages by him sustained, and the cost of suit, including a reasonable attorney's fee.

McCarran-Ferguson Act, 15 U.S.C. § 1012

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, that after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

McCarren-Ferguson Act, 15 U.S.C. § 1013(b)

(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

FED.CIV.P. RULE 56
F.R.CIV.P. RULE 56

(a) For Claimant. A party seeking to recover upon a claim, counterclaim, or cross-claim or to obtain a declaratory judgment may, at any time after the expiration of 20 days from the commencement of the action or after service of a motion for summary judgment by the adverse party, move with or without supporting affidavits for a summary judgment in his favor upon all or any part thereof.

(b) For Defending Party. A party against whom a claim, counterclaim, or cross-claim is asserted or a declaratory judgment is sought may, at any time, move with or without supporting affidavits for a summary judgment in his favor as to all or any part thereof.

(c) Motion and Proceedings Thereon. The motion shall be served at least 10 days before the time fixing for the hearing. The adverse party prior to the day of hearing may serve opposing affidavits. The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with

the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. A summary judgment, interlocutory in character, may be rendered on the issue of liability alone although there is a genuine issue as to the amount of damages.

(d) Case Not Fully Adjudicated on Motion. If on motion under this rule judgment is not rendered upon the whole case or for all the relief asked and a trial is necessary, the court at the hearing of the motion, by examining the pleadings and the evidence before it and by interrogating counsel, shall if practicable ascertain what material facts exist without substantial controversy and what material facts are actually and in good faith controverted. It shall thereupon make an order specifying the facts that appear without substantial controversy, including the extent to which the amount of damages or other relief is not in controversy, and directing such further proceedings in the action as are just. Upon the trial of the action the facts so specified shall be deemed established, and the trial shall be conducted accordingly.

(e) Form of Affidavits; Further Testimony; Defense Required. Supporting and opposing affidavits shall be made on personal knowledge, shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein. Sworn or certified copies of all papers or parts thereof referred to in an affidavit shall be attached thereto or served therewith. The court may permit affidavits to be supplemented or opposed by depositions, answers to interrogatories, or futher affidavits. When a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of his pleading, but his response, by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial. If he does not so respond, summary judgment if appropriate, shall be entered against him.

(f) When Affidavits are Unavailable. Should it appear from the affidavits of a party opposing the motion that he cannot for reasons stated present by affidavit facts essential to justify his opposion, the court may refuse the application for judgment or may order a continuance to permit affidavits to be obtained or depositions to be taken or discovery to be had or may make such other order as is just.

(g) Affidavits Made in Bad Faith. Should it appear to the satisfaction of the court at any time that any of the affidavits presented pursuant to this rule are presented in bad faith or solely for the purpose of delay, the court shall forthwith order the party employing them to pay to the other party the amount of the reasonable expenses which the filing of the affidavits caused him to incur, including reasonable attorney's fees, and any offending party or attorney may be adjudged guilty of contempt.